Thermography to Localize Parathyroid Adenoma

TO THE EDITOR: The recent article by Smith and Usselman (Wasson III EC, Smith JL, Usselman JA: Localization of a parathyroid adenoma by thermography. West J Med 121:144-146, Aug 1974) is of considerable interest.

In our experience we have successfully localized three parathyroid adenomas on three patients who had a biochemical pattern of parathyroid hyperfunction.

One word of caution that we would like to bring to the attention of thermography enthusiasts is the fact that occasionally, especially in men, one can find areas of increased temperature in the general central area of the neck where the thyroid and parathyroids would be. These areas of increased temperature are probably related to minor injuries, folliculitis or the trauma of shaving. For this reason we have elected to extend our time of observation when we do thermography for localization of parathyroid adenomas. What we do, after the initial study where we find an abnormality, is to ask the patient to come back a week or two later and repeat the study. If the area of increased temperature is persistently the same without change and we cannot palpably or by observation of the skin find any evidence of skin abnormality, we consider this to be a truly abnormal reading.

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Permanent Acupuncture Needles

TO THE EDITOR: I was interested indeed to read in the August 1974 issue, "Case Reports," the article [on acupuncture needles] by Doctors Behrstock and Petrakis [Behrstock BB, Petrakis NL: Permanent subcutaneous gold acupuncture needles. West J Med 121:140-141, Aug 1974].

Permanent acupuncture needles need not be gold, as they have pointed out. When I was working in Indonesia in 1964, I saw many patients, including a number of children, who had acupuncture needles in their bodies which showed up on x-ray studies. I noted this particularly in some children who had severe urinary infections with vesicoureteral reflux, which apparently had been treated unsuccessfully by acupuncture.

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Critical Masses in Health Care

TO THE EDITOR: Your concept of critical masses in the distribution of health care services is interesting [Critical masses in the distribution of health care services (Editorial). West J Med 121: 136-137, Aug 1974], and I believe essential to effective planning.

I would like to offer one suggestion for the planners. They might well abandon the concepts which certainly appear to be invalid, and concentrate on concepts involving modern communication and transportation. Certainly the Armed Services have demonstrated that excellent care can be provided even though sick and injured must be transported long distances. The basic concept is to bring the patient to where the doctors are, rather than the doctors to the sparsely settled rural areas and dangerous ghettos. I am convinced that the concept is feasible and believe that if the time, energy, and funds which have been devoted to invalid concepts were made available, it could be accomplished very quickly.

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Tick-borne Diseases

TO THE EDITOR: In connection with the article on tick paralysis [Emmons RW, Brewster FM, Nelson BC: Tick-bite in Oregon: Paralysis in California. West J Med 121:142-143, Aug 1974], the enclosed table of diseases transmitted by tick bites in the United States may be of interest to your readers (table adapted from Szalay[1]).

Tick-borne Diseases[1]

Disease	*Infectious Agent*
Tick-borne typhus e.g. Rocky Mountain spotted fever; Q fever	Rickettsia
Colorado tick fever	Virus
Relapsing fever	Spirochete
Tularemia	Bacillus
Babesiosis	Intracellular RBC parasite
Tick paralysis	Tick toxin
Powassan virus encephalitis	Virus

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REFERENCE

1. Szalay GC: Tick-borne disease. Am J Dis Child 127:909, Jun 1974